rachna program
2001-2006

women and child health at scale

working paper series

paper 1

what rachna has done so far:
program description

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What RACHNA has Done So Far: Program Description

Background

The RACHNA program of CARE India included two USAID-supported projects: the second phase of Integrated Nutrition and Health Project (INHP-II), which focused on child health and nutrition, and the *Chayan* Project, which supported interventions for promoting birth spacing and the prevention of transmission of HIV/AIDS among groups at high risk. INHP -II, built upon the lessons and experiences of the first phase, was implemented in 747 Integrated Child Development Services (ICDS) blocks[1] in 78 districts across nine states[2] from October 2001 – December 2006 to complement the maternal and child health and nutrition (MCHN) efforts of the ICDS and the Ministry of Health and Family Welfare (MoHFW) programs. To achieve its goal of *"sustainable improvements in the nutrition and health status of seven million women and children"*, INHP-II adopted a two-track approach – supporting service providers to improve the quality and coverage of MCHN services and systems and engaging communities to support better infant feeding and caring practices and sustain activities for improved maternal and child health and survival. The implementation was facilitated by small program teams of CARE, located at the district, state and national levels, and working closely with the functionaries of the ICDS program and the programs of the MoHFW, and with a range of partners, including local NGOs and Community-Based Organizations (CBOs). The main strategies were strengthening of existing systems, behavior change communication and capacity building.

In July 2002, the *Chayan* project was added to INHP-II, and along with a few other, smaller health projects run by CARE-India, RACHNA, an umbrella program was created. The rural component of *Chayan* (*Chayan* rural) supported the strengthening of family planning services for birth spacing and the prevention and management of Reproductive Tract Infections and Sexually Transmitted Infections (RTI/STI). It operated in 29 INHP-II districts in four out of the nine INHP states – Uttar Pradesh, Rajasthan, Chhattisgarh and Jharkhand. *Chayan* rural aimed at increasing contraceptive prevalence rates in men and women in reproductive age groups. It increasing awareness and treatment seeking behaviors for reproductive tract infections and was operationally integrated with INHP-II. The urban component of *Chayan* (*Chayan* urban), attempted to increase safe sex practices and the treatment of RTI/STI/HIV prevention among high-risk groups, especially female sex workers, truckers and migrants. It also included interventions for promoting life-skills and awareness on RTI/STI/HIV prevention among youth, implemented in selected urban blocks of ICDS.

This paper provides an overview of the background, objectives, interventions and impact hypotheses of INHP-II and *Chayan* rural, the implementation approaches used and their evolution over time. This series of papers publishes, for the first time, details of the interventions and results of INHP-II and *Chayan* Rural projects. Results and lessons from the *Chayan* urban project had been published as *HIV Prevention in Vulnerable Indian States* in December 2006, which is reprinted as Paper 9 of this series.

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[1] A block is an administrative sub-unit of a district, having a population of around 100,000, and often larger. An ICDS block is usually identical to the administrative block, and comprises about 100 *Anganwadi* Centers (AWC). Not all blocks in a district and not all villages and hamlets within a block may be served by the ICDS program. INHP-II was designed to be implemented only in ICDS-served blocks, but did not necessarily cover all ICDS blocks in the districts where it was implemented.

[2] These include Andhra Pradesh, Bihar, Chhattisgarh, Jha[illegible]hand, Madhya Pradesh, Ori[illegible]n, Uttar Pradesh and West Bengal. Since the program was implemented in Bihar only from [illegible]e 2004 onwards, results p[illegible] [illegible]nly from [illegible]her eight states.

Program Design

This section provides a brief overview of the RACHNA program design. More details, including a historical perspective are available in the RACHNA Mid-term Document.[3]

Integrated Nutrition and Health Project

INHP was conceived as a ten-year project with two distinct phases. The first phase of the INHP was implemented in seven states, Andhra Pradesh, Bihar, Madhya Pradesh, Orissa, Uttar Pradesh, Rajasthan, and West Bengal, during October 1996 to September 2001. It aimed to improve the nutritional status of women and children under two years of age by closely working with the ICDS, RCH, a range of non-government organizations (NGOs) and Community Based Organizations (CBOs). The interventions package included targeted supplementary feeding, Iron Folic Acid (IFA) supplementation and Tetanus Toxoid (TT) for pregnant women and immunization for children across all areas. Early, exclusive breastfeeding and timely, adequate complementary feeding practices were promoted in about 10 percent of the INHP-I areas.

In 2001, the final evaluation of INHP-I was conducted. One conclusion was that: *"CARE's institutional transformation from food management organization to a nutrition and health development group has been impressive. Its role in INHP – catalyst, facilitator, capacity-builder, technical supporter, is appropriate and has made an outstanding contribution to the convergence of health and nutrition services. The project has succeeded in bringing together ICDS and Health Department policies, operations and service delivery and government has become more effective in reaching high coverage for health services as a result. There is indirect evidence that INHP is reducing the under-nutrition (low weight-for-age) which synergistically increases the risk of children dying form common childhood illnesses".*

At the end of INHP-I, CARE undertook extensive problem analysis and multi-stakeholder consultations, drawing lessons from evidence and experiences both within and outside of CARE to determine the priorities for INHP-II. This process necessitated certain refinements and, in some cases, shifts from INHP-I. These included:

- Shifting focus from the block as a unit for CARE's operation to the district
- Placing a team of three to four professionals at the district level with specialized competencies, with each having a set blocks within a district
- Addition of neonatal health interventions
- Shifting focus from general targeting of pregnant, lactating women and those with children under two to the most critical points during these periods with specific interventions

[3] The document, Reflections of a journey: RACHNA Midway, is available from the CARE-India website and on request.

- A deliberate approach to defining and replicating best practices
- Shifting from only implementation support to leaving behind strengthened supply chain, training and information systems
- Deliberate focus on tracking left-outs and dropouts to minimize gender based and social exclusion.

Having programmed USAID Title II food commodities (Corn Soya Blend and Refined Soybean Oil) through ICDS for decades, ICDS was the natural ally and nodal point for all operations. The AWC was the unit of implementation. The RCH program was a necessary partner for fulfilling several health-related objectives. All these were carry-overs from the previous phase. The key components of the INHP-II design are presented in the Box 1.1.

Box 1.1: Integrated Nutrition and Health Project II (2001-2006)

Goal

Vulnerable families achieve sustainable improvement in the nutrition and health status of seven million women and children in approximately 70 districts across eight states in India by 2006.

Sub-objectives:

- Service providers (especially auxiliary nurse midwives and *Anganwadi* workers) improve the quality and coverage of maternal and child health services and key systems, including training, supply chain management and information management
- Communities sustain activities for improved maternal and child survival

Key Target Groups:

- Pregnant and lactating mothers
- Children under three years of age

Impact Objectives:

- Reduction in infant mortality
- Reduction in malnutrition among children

Technical Interventions:

- Antenatal care
- Newborn care
- Nutrition essentials
- Immunization

Approaches:

- Strengthening systems
- Community engagement
- Behavior change communication

Partners:

The Integrated Child Development Services Scheme (ICDS) of the Ministry of Women and Child Development, Ministry of Health and Family Welfare, Local NGOs, *Panchayati Raj* Institutions and Community-based Organizations, USAID

Technical Assistance:

- BASICS, LINKAGES, Johns Hopkins University, the FANTA project and IMMUNIZATION Basics

The INHP-II Interventions Package

INHP prioritized interventions that had evidence of making a significant contribution to the reduction of malnutrition and mortality. Considering the scale at which they had to be implemented, it was critical to select interventions that were simple and doable at scale in a relatively short span of time

The INHP-II promoted a set of interventions that were the explicit priorities of ICDS and RCH II programs. However, there was little evidence that these interventions were being implemented by the national programs with sufficient rigor. As described in a later section, INHP-II first used a set of "best practices" that had emerged from INHP-I for strengthening service delivery and bringing about behavior change, and, as more lessons were learnt, evolved more direct approaches for increasing the focus and accountability of these programs in implementing the chosen interventions.

The interventions supported by INHP-II included the following:

- **Antenatal Care:** INHP-II focused primarily on those antenatal interventions that might improve neonatal outcomes, including antenatal check-ups, TT vaccination, iron & folic acid supplements, supplementary feeding, increased dietary intake, reduced workload, rest and preparations for safe delivery.

- **Community-based Newborn Care:** Recognizing the centrality of neonatal mortality to child mortality, the program used the available evidence base, globally and within the country, to identify the common proximate causes of neonatal mortality and interventions likely to affect this. The challenge was to find practical ways of improving neonatal survival, that were scientifically sound, user-friendly and feasible to implement through the existing delivery mechanisms and in the current policy environment. These included: cleanliness in handling the neonate at birth and in the first week/month, warmth at birth and in the first week/month, early and exclusive breastfeeding, and early recognition (through simple clinical signs) and care of the premature/low-birth-weight baby (more aggressive attention to cleanliness, breastfeeding and warmth). A review of global and Indian evidence indicated that these simple interventions, if practiced in most homes, could bring about a 20-30 percent reduction in neonatal mortality over two to three years. The project did not address directly the management of childhood illnesses; hence most of the reduction in Infant Mortality Rate (IMR) would come from interventions for newborn care.

- **Nutrition Essentials:** INHP emphasized the critical nutrition interventions required for adequate growth and development as a package during the first two years of life including the period of pregnancy. These included: early and exclusive breastfeeding, appropriate complementary feeding and vitamin A, iron and folic acid supplementation for children. Some of the antenatal and neonatal interventions, as mentioned above, were also key components of the essential nutrition package, as these together would lend to improving birth weight and increasing iron stores in the mother and child.

- **Child Immunization:** Recognizing that low immunization coverage was a threat to child survival and nutrition, INHP-II focused on complete and

timely primary immunization of all children, including the BCG, DPT, OPV and Measles vaccines that were then included in national immunization program. Hepatitis B was added state-wide only in Andhra Pradesh by the end of INHP-II. INHP-II promoted strategies to minimize left-outs and drop-outs by strengthening service delivery systems and tracking systems at the village level.

- Food Supplementation: INHP-II supported the supplementary feeding invention of INHP by providing the in-kind commodity i.e., corn-soya blend (CSB) and refined vegetable oil (RVO) to be used as a nutritional supplement and an incentive to draw the most vulnerable women and children to utilize health services. While the intention was to continue food supplementation throughout the program period, commodity supply was disrupted in mid-2002 due to concerns expressed by the Government of India about genetically engineered sources of the CSB. The CSB supply ceased by early 2003, while oil supplies continued to be programmed until the end of INHP-II, together with grains supplied by the respective state governments.

Box 1.2: The *Chayan* Project (2002-2006)

Objectives:

- Men and women in program areas are better able to choose the number and timing of their children
- Men and women in program areas are better able to protect children from RTI/STI and HIV infection

Target Groups:

- Men and women in the reproductive age group
- Youth (males and females in the 15-24 years age group) in selected cities
- High-risk behavior groups for HIV transmission (female sex workers, truckers and their associates, male migrants)

Impact Objectives:

- Increase in contraceptive prevalence rate
- Increase in safer sex practices, especially among high risk behavior groups

Technical Interventions:

- Among men and women in the reproductive age group: birth spacing including informed choice for contraception, prevention and treatment of STI/RTI through safe sex practices and referral for treatment
- Among high-risk behavior groups: condom promotion, improved referral and treatment follow-up for STI/RTI and communication for improved safe sex practices and facilitation of an enabling environment
- Among youth: promotion of life skills and improving access to youth-friendly health services

Implementation Approach:

- Systems strengthening
- Community engagement
- Private sector partnerships

Partners:

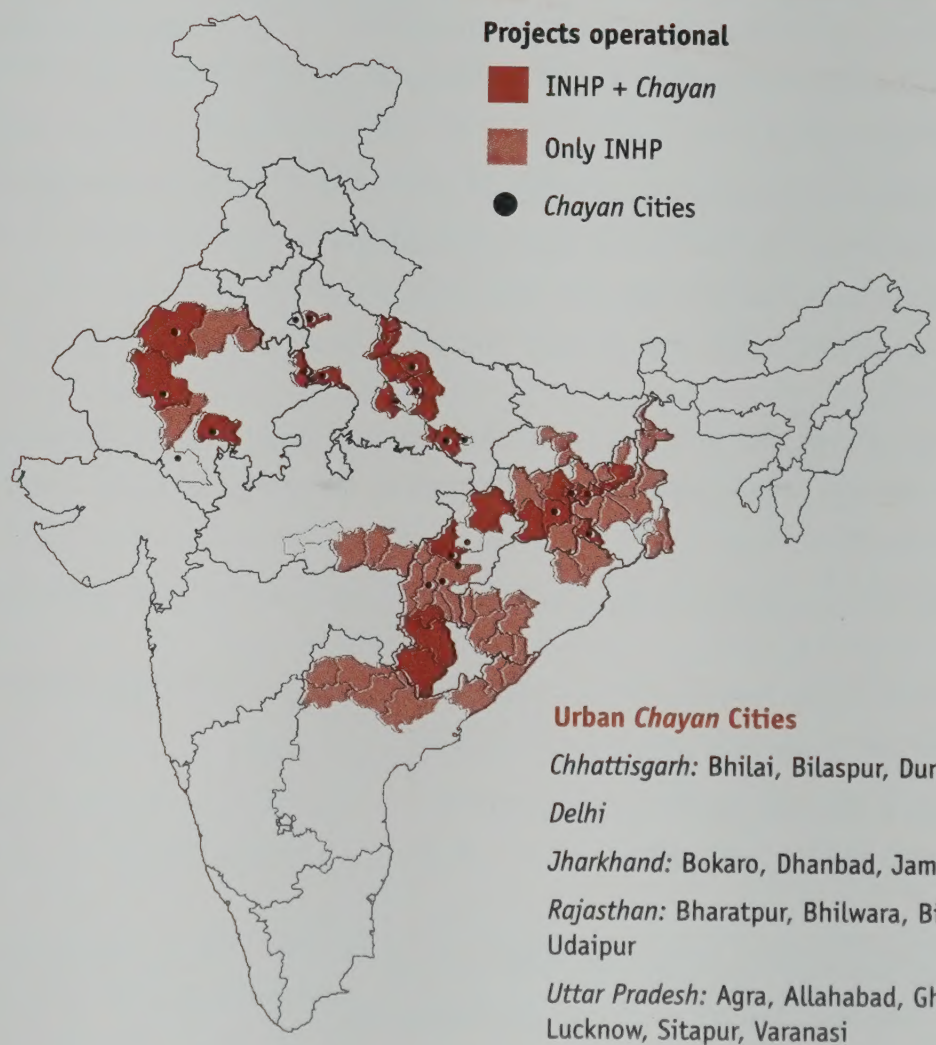
Ministry of Health and Family Welfare through National AIDS Control Organization and State AIDS Control Societies, Ministry of Women and Child Development through local NGOs, Corporate houses, Industries, Panchayati Raj Institutions and Community-based Organizations and USAID.

Chayan Rural

In 2002, USAID provided further support to integrate reproductive health and HIV prevention interventions with INHP-II through *Chayan*. *Chayan* supported the goals of the GoI's National Population Policy and National HIV/AIDS Policy, through a broad-based approach to family planning and a targeted approach to HIV prevention. This section provides details of the *Chayan* rural design, which was informed by the significant gaps that existed in the reproductive health interventions in the northern Indian states. Box 1.2 provides an overview of the *Chayan* design while the rest of this paper covers only *Chayan* rural.

Geographic Coverage of RACHNA

The INHP-II was implemented in 94,593 AWCs in 747 ICDS blocks in 78 districts across nine states including Andhra Pradesh, Bihar,[4] Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh and West Bengal. While the geographic area in terms of the states largely remained the same as INHP-I,[5] there were changes in the districts covered. The family planning interventions of *Chayan* rural were implemented in 29 of the INHP-II districts in the states of Chhattisgarh, Jharkhand, Uttar Pradesh and Rajasthan. The program areas were predominantly rural, with a significant proportion of Scheduled Castes (SC) and Scheduled Tribes (ST).



Urban *Chayan* Cities

Chhattisgarh: Bhilai, Bilaspur, Durg, Korba, Raipur

Delhi

Jharkhand: Bokaro, Dhanbad, Jamshedpur, Ranchi

Rajasthan: Bharatpur, Bhilwara, Bikaner, Jodhpur, Udaipur

Uttar Pradesh: Agra, Allahabad, Ghaziabad, Kanpur, Lucknow, Sitapur, Varanasi

[4] CARE phased out its support to Bihar at the end of INHP-I as most of the programming districts fell into the newly formed state of JH. However, three districts of Bihar were included in the program in 2004 in response to the request from Government.

[5] The number of states increased from seven in INHP-I to nine in INHP-II due to the bifurcation of the former state of MP into CG and MP and the former state of Bihar into Jharkhand and Bihar.

The RACHNA Impact Hypothesis

The critical path to achieving the child health, nutrition and reproductive health objectives of RACHNA rural was articulated as the "Impact Hypothesis" of the program, which outlined how critical actions at the system and community level translate into desired changes in service coverage and behaviors. This is described in Box 1.3.

An Operational Strategy was developed to define the sequence of inputs and processes leading to outputs and outcomes. These were to help existing systems enhance effectiveness in delivering services and to help communities become effective owners and drivers of their own change.

Box 1.3: The RACHNA Impact Hypothesis

Facilitating the ICDS and RCH programs to focus on interventions most likely to be effective in reducing mortality and malnutrition in children and improving contraceptive use and safe sex practices will lead to measurable improvements in critical process and outcome parameters.

Sharp program focus and increased capacities of functionaries of ICDS and RCH programs at all levels, as well as the strengthening of key systems, would ensure:

- Increased contacts by service providers and volunteers with individuals and families, for counselling and for provision of services
- Improved efforts by service providers and volunteers to include excluded communities and individuals in the net of services
- Improved availability and access to quality antenatal, immunization, nutrition, family planning and STI/RTI management services and supply of contraceptives in the public and private sector

→ Improved behaviors and practices related to newborn care, nutrition, immunization, family planning and STI/RTI prevention and care seeking

→ Improved coverage of services

→ Improved use of contraceptives including condoms

Mobilizing communities and building ownership about the importance of appropriate health, nutrition, reproductive health and sexual behaviors would lead to sustained behavior change and ensure regular delivery and utilization of services.

Increased awareness among community groups and greater capacity of local governance institutions would lead to:

- Increased community capacity to demand health and nutrition services, supplies and information
- Better program monitoring for holding service providers accountable for problem solving at all levels
- Increased community ownership and intervention in promoting behavior change at family and individual levels

→ Increased delivery and utilization of services

→ Faster behavior change

Program Management and Delivery Mechanisms

The RACHNA program was primarily delivered through the existing systems and structures of the Government, the ICDS and RCH functionaries. RACHNA acted as an external catalyst and facilitator for making these programs sharper, more focussed and effective by providing the necessary technical, managerial and resource support at all critical levels of implementation.

The district was the primary unit of planning, implementation and program management for RACHNA. At the district level, RACHNA operated through district-based teams with four to six officers having complementary roles and competencies. The district teams worked with the officials and functionaries of the ICDS and RCH programs, NGO partners and other critical stakeholders. The district team comprised the GPO (Government Partnership officer), responsible for liaison with the district administration and ICDS and RCH program leadership, the DPO (Demonstration Partnership Officer), responsible for engaging with the NGO partners and establishing demonstration sites, the CBO (Capacity Building Officer), responsible for all capacity building activities in the district and the MO (Monitoring Officer), responsible for monitoring the food commodity technical assistance. In *Chayan* districts, there were additionally, a TC (Training Coordinator), a Social Marketing Officer (SMO) and a Youth Coordinator (YC), the last only in the urban blocks where activities related to youth were conducted. Typically, a district team was responsible for one or two districts based on the programming context. The states with a complex programming environment had higher numbers of district teams.

A three to four member program management team provided leadership to the RACHNA program. This team was led by a State Program Representative and supported by two to three Regional Managers. The number of Regional Managers differed depending upon whether it was only an INHP state, or also included *Chayan*. Each Regional Manager provided programmatic and managerial leadership for the assigned three to four districts. Two to three Documentation Officers, one Monitoring and Evaluation Officer and other support staff provided assistance to the state program management team.

At the CARE India headquarter level, a Senior Program Director assisted by four Regional Program Directors and one Technical Director provided the programmatic, managerial and technical leadership. Each Regional Program Director, assisted by a Technical Program Coordinator, was responsible for providing needed operational support as well as channelling technical assistance to two to three states. The Technical Director with a team of technical specialists provided technical support and guidance to the program.

Box 1.4 presents the organizational schematic of RACHNA and its relationship to the ICDS and Health Programs and the *Panchayati Raj* hierarchy.

RACHNA worked through a large network of local NGOs to provide its catalytic support to the ICDS and RCH functionaries, especially those at the operational levels and the supervisors and managers at sub-district levels. Over time, RACHNA also engaged a large number of Community Based Organizations (CBOs, such

Box 1.4: Relationship of CARE/RACHNA organizational structure to key government programs

Level (Population covered)	*Panchayati Raj*	Health (rural)	ICDS	CARE/RACHNA
National	Ministry	Ministry	Ministry	National Program Management Team
State	Ministry	Ministry, Directorate	Ministry, Directorate	State Program Management Team (State Program Manager, 2-3 Regional Managers)
District (1,000,000+)	*Zila Parishad*/Panchayat Samiti	Chief District Health Officer (DHO/CDHO/DM&HO)	District Program Officer (DPO/DWCDO)	District Team (3 officers for INHP and 2 for *Chayan*)
Block (100,000+)	Block/Janpad/*Kshetra*/ Intermediate *Panchayat*	Block Medical Officer, PHC/MO	Child Development Project Officer (CDPO)	Staff of NGO partners (one per block)
Sector (ICDS) (20,000+)	*Gram Panchayat*	MPHS (Male, Female)/ LHV, one per 3-4	Sector Supervisor – one per 20-25 AWW	
Village (~1000)	PRI members	MPHW (Male, Female) one each per sub-center (3-5000), Trained Birth Attendants	AWW	Change Agents, SHG members

Different states use different designations for district and block level personnel. Each cell carries equivalent designations. DHO = District Health Officer, DM&HO = District Medical and Health Officer, DWCDO = District Women and Child Development Officer, PHC/MO = Medical Officer - Primary Health Center, MPHS = Multi-Purpose Health Supervisor, LHV = Lady Health Visitor (same as MPHS Female), MPHW = Multi-Purpose Health Worker. Often, the MPHW (Female) is called Auxiliary Nurse Midwife (ANM), AWW = *Anganwadi* Worker, PRI = *Panchayati Raj* Institutions, SHG = Self-Help Groups (of women). A *Gram Panchayat* usually comprises all residents of a cluster of villages, often equivalent in population to an ICDS sector.

The staff of RACHNA included the national and state level Program Management Teams and the District Teams. Local NGO partners assisted District Teams in implementation. In the early part of the program, NGO partners were mainly charged with developing and maintaining Demonstration Sites (DS); in the latter part, they were engaged to help facilitate engagement with ICDS and Health at Sector and Block levels. The arrows represent the levels at which RACHNA teams engaged the government programs. Change Agents were community volunteers, 3-5 per village, recruited and trained by RACHNA in coordination with ICDS and Health programs. The Change Agents were often supported at the village level by women's Self-Help Groups, besides the AWW and ANM.

as Self-Help Groups), *Panchayati Raj* institutions (PRIs), academic and research institutions, private sector service providers, social marketing agencies, corporate social initiatives, professional bodies and motivated individuals and professionals to complement and support the efforts of the government systems. This engagement was instrumental in mobilizing communities for greater ownership and facilitating social changes that promote positive household level health and nutrition *behaviors*.

At the national and state levels, RACHNA collaborated with a number of international and UN agencies with similar interests and overlapping geographic presence to address health and nutrition priorities.

INHP-II benefited from quality technical assistance in the areas of capacity building, strengthening systems, monitoring, evaluation and evidence based documentation from BASICS.[6] The FANTA project of USAID provided technical assistance in food transition and phase-out strategies. The International Food Policy Research Institute (IFPRI) conducted a study on food transition. In addition, CARE with support from USAID, collaborated with John Hopkins Bloomberg School of Public Health for implementing two evaluation research (ER) studies.

Key Program Inputs

RACHNA adopted a *demonstration and replication* approach for scaling up the successful practices through government systems. Ten percent of demonstration sites were developed to innovate and develop best practices that could help solve operational problems faced by the ICDS and RCH programs. These sites served as learning laboratories to identify and demonstrate effectiveness of existing best practices in solving operational problems and to convince the critical decision-makers to take the lessons to scale. Initially, the best practices helped in ensuring uniform focus across states and districts to deliver the interventions. As implementation progressed, based on lessons learned and recommendations from the mid-term review, RACHNA refined to this approach. Although the implementation of the INHP-II and *Chayan* projects was initiated at different time periods, there were advantages in linking them together due to largely overlapping populations and the value of engaging both the RCH and ICDS. The INHP and *Chayan* projects provided many program inputs for translating the interventions into doable actions at community and system level. These included:

Capacity building: Capacity building was the primary tool to take the proposed interventions to scale. This approach was different from conventional training approaches and had three components – technical content, process skills and motivation. Besides formal training, it included non-training inputs such as cross-visits, joint program reviews, supportive supervision and on-going capacity building through review meetings. RACHNA's capacity building efforts extended to functionaries of the ICDS, RCH, NGO staffs, public and private sector service providers, community volunteers called change agents (CA), reproductive health change agents (RHCAs) as well as members of CBOs and representatives of PRIs.

Behavior Change Communication (BCC): The BCC approach was central to the program, complementing the capacity building efforts. It was expected to bring about changes in behaviors at the household level by addressing barriers to behavior change through use of multiple channels of communication, including mainly, interpersonal communication. Formative research conducted in the initial phase across states, helped identify barriers in different socio-cultural contexts and was useful in the development of culturally appropriate communication materials for different contexts. Efforts were made to work with other stakeholders to get consensus on the key messages and avoid any duplication.

[6] BASICS is one of the global technical assistance projects of USAID. It was funded from USAID/India field support funds to provide technical assistance to INHP-II.

System Strengthening: The approach of system strengthening focused on building capacities within the ICDS and RCH programs to sustain changes brought about by RACHNA. Specifically, this meant helping the ICDS and RCH programs improve the food and health supply chain for more effective delivery of essential supplies and services, strengthening the information systems for better monitoring and influencing the training content and approaches of the current training institutions to ensure enhanced capacities of a larger number of functionaries. INHP-II placed significant level of effort and resources into strengthening the food supply chain management to improve the supplementary feeding component of ICDS.

NGO Partnerships: The partnerships with local NGOs for developing about 10 percent of the AWCs as demonstration sites was aimed at helping the ICDS and RCH programs adapt and replicate certain processes in a phased manner in other areas called replication sites. NGOs played important roles in mobilizing communities and implementing context-specific innovations to establish ways of improving coverage for services, influencing household level behaviors and capacity development of the ICDS and Health supervisors on monitoring, ongoing reviews and field visits.

Addressing Inequities: RACHNA explored the gender and social equity dimensions of child health and nutrition in different ways, and attempted to find ways to address them. Disaggregated data analysis was done to determine whether the projects were reaching the most marginalized families and girls. The inclusion and tracking systems were improved to show who were the left outs and drop-outs from key services. At the community level, the program also integrated gender and equity dimensions into capacity building, BCC activities and the best practices.

The above descriptions of program inputs apply to both INHP and *Chayan*. The following are some of the approaches that were distinct to *Chayan* rural components.

Improving Access to Contraceptives: *Chayan* rural focused on making available and improving access to a basket of socially marketed contraceptives to the communities and also strengthening the delivery of free supplies provided through the RCH program. CARE identified a lead partner, Population Services International (PSI), to establish and scale up social marketing outlets in the AWC catchment areas and support in behavior change. The other social marketing agencies with which RACHNA collaborated include DKT-India and Hindustan Latex Ltd.

Public Private Partnerships: *Chayan* rural envisioned an enhanced role for private sector providers in family planning and STI/RTI management services by standardizing their practices and then linking them with communities. A wide range of qualified and unqualified practitioners, who were providing these services with varying degrees of quality, constituted the private sector partners in the *Chayan* operational areas.

CAFE

Monitoring and Evaluation Design for RACHNA

Monitoring and Evaluation (M&E) systems were designed separately for the INHP and *Chayan* Projects, given the different time frames of each of the projects, and were based on the lessons learnt from INHP-I as well as the recommendations from the final evaluation. *Chayan* rural's on-going monitoring system that was built upon the frame of the INHP-II system, however, given that the universe for *Chayan* was a subset of the universe of INHP.

The program monitoring system was built of two main components. A brief set of indicators was reported monthly from every AWC in the universe, mainly related to the organization and regularity of food supplementation, immunization and vitamin A supplementation services on Nutrition and Health Days (NHD). This was collated at different levels and made available up to the national level. This was complemented by reports from NGO partners on qualitative aspects of the program. The other component was a set of household sample surveys, called periodic rapid assessments (or RAPs), and conducted annually in a panel of one district of each of the eight main program states. These surveys gathered information on outcomes related to service coverage and behavior change as well as nutritional status, which was not reliably available from any other source, and provided a sense of direction to the field teams of ICDS and RCH programs, as well as RACHNA teams. In *Chayan* districts, these monitoring systems included information and indicators related to reproductive health and spacing methods as well. In the last two years of the program, as program strategies and roles of NGOs changed, there were corresponding changes in the monitoring system.

The evaluation design comprised two components: pairs of baseline and endline surveys, separately for INHP and *Chayan*, and two evaluation research (ER) studies, one each to study the effectiveness of the INHP interventions package on neonatal mortality and child malnutrition. While the baseline and endline surveys represented the respective project universes, these latter studies were limited to one intervention and one comparison district in the case of newborn ER and two districts each in the case the nutrition ER. Detailed descriptions of the methodology used in these surveys and in the RAPs referred to above, are available in paper, *Methods Used for Assessments in the RACHNA program,* in this series.

Evolution of RACHNA: Reflecting, Learning and Refining

This section describes the evolution of the implementation approaches and the mechanisms instituted for continuous learning to inform and refine implementation. This was considered important, particularly considering the scale of the program. The journey of RACHNA between 2001-2006, the refinements over time and the basis for them are briefly described below. More details of how the approaches to engaging systems changed are available in the paper, *Working with Existing Systems: Lessons from INHP*, in this series.

The Emergence of Best Practices

At the beginning of the INHP-II, four best practices were identified for scale up, from among many potential candidates that the INHP-I experience had thrown up. These were identified through internal reflections using quantitative and qualitative evidence and recommendations from the INHP-I midterm and end-line reviews by engaging stakeholders across states. These best practices became a significant part of the program. They are outlined in Box 1.5.

Each of the best practices was in essence, a managerial solution to a common operational problem or issue faced by the functionaries within the system and communities, field tested over a variable period of INHP-I and adapted for wider use in INHP-II. It was understood that these best practices would form a common minimum base for INHP-II, and that, as more problems were tackled and lessons learnt, more such solutions would be added. Such innovation was expected to be a function of the demonstration sites.

Early Implementation Phase

The period from October 2001 to April 2002 marked the transition from INHP-I to INHP-II in terms of development of an operational strategy and orientation of the INHP-II staff. An operational strategy, informed by the recommendations from the INHP-I evaluation and the INHP-II commitments was developed during this period to guide the staff. During the same time, informed by the operational strategy, capacity building and behavior change communication elements were detailed and materials/tools were developed. The program monitoring system that existed during the INHP-I was reviewed and revised in consultation with critical stakeholders.

During the operational strategy development process, a number of operational issues emerged around the implementation of technical interventions necessitating development of a number of tools that might potentially facilitate

Box 1.5: INHP-II "Best Practices"

1. **Community Volunteers:** A cadre of volunteers called change agents (CAs) representing and catering to a cluster of 15-25 households, working with support of the AWW and community organizations to promote child health and nutrition practices. In *Chayan* rural areas, Reproductive Health Change Agents (a male and female) were to provide information and counselling on family planning choices to men and women of reproductive age.
2. **Nutrition and Health Day (NHD):** A Nutrition and Health Day is a fixed-day of the month when take-home rations (THR) of supplementary food are distributed by the AWW and an ANM visits the AWC to provide a package of health and nutrition services including immunization, antenatal check-ups and micronutrient supplements. In *Chayan* rural areas, modern contraceptives were also to be provided.
3. **Community Based Monitoring Systems (CBMS):** Individual-based and community-based tools to track caring practices and service utilization, and to facilitate problem seeking and solving by community groups. Different tools were developed and used across states. Social Maps (SM) were the most commonly used tool for defining catchment areas and community monitoring. Self-Monitoring Tools (SMT) consisted usually of wall drawings of culturally appropriate symbols, each element of which represented a certain aspect of care during pregnancy or infancy, and which could be used as an aide memoir by individual mothers during this period.
4. **Block Level Resource Mapping (BLRM):** A process of joint program review by ICDS and Health functionaries at the block levels, which involved the use of maps to indicate the distribution of resources and patterns of service coverage.

implementation. Moreover, since two of the best practices (CBMS and BLRM) were not implemented in all states during the first phase, they needed to be tested to see whether they were actually useful in producing results.

Another concept that was carried over from INHP-I was that of the "demonstration site". Demonstration sites were a few selected AWCs (10 percent) where the "best practices" were established as solutions to specific operational problems. These demonstration sites were intended to serve as the learning ground for the government counterparts to learn and replicate the best practices in the rest of the AWCs. Partnerships were developed with local grassroots NGOs in each district to help establish demonstration sites with the four best practices, and to help innovate further particularly to evolve ways of mustering the community's interest and participation in the program – considered vital for long-term sustenance of the program. The involvement of the ICDS and Health programs in this approach was integral in the sense that AWWs and ANMs, and their supervisors at sector and block levels, had assigned roles to play in the execution of each best practice. Recognizing that the four best practices did not fully address or resolve all operational problems, it was understood that the demonstration sites, spread widely across the breadth of the program area, would serve as learning laboratories for identifying fresh solutions for operational problems, some of which may be only locally relevant, while others with greater potential, might one day become best practices in their own right, to be used program-wide. The ICDS and Health programs were thus critical partners, and indeed the main actors in this strategy beyond the realm of the demonstration sites, to which NGOs were restricted.

With technical assistance from BASICS, a plan was developed in April 2002 to follow the processes in a small number of demonstration sites across states to gather early evidence and lessons to inform the refinements across the program. These sites were called the early learning sites (ELS). In selected districts of all states except for Bihar, three to five demonstration sites were selected as early learning sites to learn about the use of best practices and establish links with the corresponding sector, block and district levels over a six months period. A quantitative assessment of the ELS was done during 2003 to gather evidence and capture early lessons to inform the rest of the program. The lessons from the ELS assessment are listed below:

- Organization of Nutrition and Health Days and recruitment and training of CAs were effective with respect to the operational investment.
- The real objective of BLRM remained unrealized as joint planning and problem solving was not only resource intensive, but also required that officials involved in this process, fully appreciated the use of the information generated from their areas for strengthening strategies.
- The use of social mapping within CBMS was useful in defining catchment areas. However, the regular use of community based processes for minimizing left-outs and drop-outs and identifying families for more focused behavior change activities, was not as fructifying.

- The small improvements in newborn care and nutrition related behaviors underlined the need for strengthening the BCC strategy. The investment in training field functionaries could be utilized in reaching more people with usable information particularly on home based newborn care and appropriate infant feeding.

During this period it was also determined that, considering the scale to be reached over the life of the program, replication would begin along with the establishment of new demonstration sites. Recognizing the intensity of efforts, resources and capacities, it was determined that replication would reach about 25 percent of AWCs by late 2003 and 50 percent by late 2004, replication being defined mainly as the spread of best practices to these areas. These were termed Replication Sites (RS) to distinguish them from the 10 percent Demonstration Sites (DS) It was understood that the strengthened training and information systems, as well as a process of diffusion would take the best practices to full project scale thereafter.

The results provided crucial information for program review to both, INHP teams as well as the ICDS and RCH programs. These surveys also helped introduce an outcomes-focus at all levels, and provided evidence which influenced mid-course corrections to the project strategy at the mid-term, as discussed later.

Managing the Food Transition and Commodity Technical Assistance

Until July 2002, two food commodities, Corn-Soya Blend (CSB), and Refined Vegetable Oil (RVO) were used for direct distribution through ICDS. In July 2002, the Genetic Engineering Approval Committee (GEAC) of the GoI disallowed import of CSB failing certification from the U.S. government that CSB did not include genetically modified organisms. Eventually, after a difficult transition in each state, all the nine state governments provided the grain to replace the CSB. As this transition took place in the middle of the Indian financial year, it posed a number of problems for the state governments to find resources to purchase the food for the INHP-assisted areas. Subsequently, INHP-II focused on providing technical assistance to ICDS to strengthen the grain supply chain and aligning the oil with state government grains.

The Chayan Project and the Birth of RACHNA

In 2002, additional funding from Population, Health and Nutrition Division of USAID allowed CARE to build family planning and HIV prevention interventions onto the program platform of INHP through the *Chayan* Project. The family planning interventions of *Chayan* were implemented in 29 districts of four states, which formed a subset of the INHP program areas, targeting men and women of reproductive age in the ICDS catchment areas. HIV prevention interventions targeting youth and high-risk behavior groups were implemented in 22 cities across the same four states and selected slums of Delhi, largely in areas not covered by INHP.

The rural *Chayan* aimed to increase the use of modern spacing methods by at least three percentage points over five years and had its own set of "outcome" level indicators, reflecting behavior change and change in access to contraceptives. With this integration, both these projects were brought under a common program

umbrella which was named Reproductive and Child Health Nutrition and HIV/AIDS (RACHNA).

The best practices of *Chayan* rural were evolved based on the experiences of CARE and other agencies in implementing reproductive health interventions. The following were the two best practices added through *Chayan* rural:

- **Reproductive Health Change Agents (RHCAs):** Similar to the CAs identified for the INHP, the RHCAs are also active, interested members from the community, preferably a male and a female couple, who could act as promoters of positive reproductive health behaviors on a voluntary basis. They also act as links between communities and health service providers for referral for contraceptive services and treatment, and carry out follow-ups.

- **Community-based Organizations (CBOs):** CBOs are groups of men and women from within the community who facilitate and promote changes in reproductive health behaviors, act as pressure groups for ensuring regular quality services by service providers, support the local governance structures of PRIs and its sub-committees like village health committees, by providing them information on service delivery and utilization.

RACHNA at Mid-term: Learning What Works and What Does Not

The RACHNA program has been a learning program, responding to changes prompted by internal reflections and changes in the external environment for greater program impact. Consistent efforts have been made to tap the emerging lessons from its implementation and sharpen strategies.

Shift from 'Best Practices' as only Solutions to Overcoming Operational Bottlenecks.

A lesson that INHP-II learnt fairly early, through assessments of early learning sites in 2003, was that although it was easy to implement best practices, these may not have significant influence on *behaviors* or service coverage, and that some best practices such as the CBMS were not feasible at scale given the intensity of the process. They also revealed that despite the capacity building efforts made in the program, aspects, such as contacts and advice for behavior change, were weak. There were indications early on in the program that, in the demonstration sites, the enthusiastic NGO staff tended to dominate implementation, often to the exclusion of systems functionaries from the process – making it difficult to predict how the system functionaries would cope on their own in replication sites.

Development of Essential Nutrition Actions Guidelines

It was recognized that nutrition interventions particularly the breastfeeding and complementary feeding interventions did not get the needed attention and were often perceived as difficult to implement. This recognition led to the development of an Essential Nutrition Actions framework which included guidance on how to deliver these interventions at district, block, sector and village levels; a three step counseling guide; age specific feeding recommendations and job aids for problem solving. This framework was developed with the primary purpose to demystify implementation of nutrition interventions and give these the needed push.

It was also learnt that contacts by service providers were found to correlate best with better behaviors and service coverage, and opened up the possibility that monitoring contacts might prove to be an effective tool.

Deeper Probing and Use of Data

The HMIS of the project, developed and established by mid-2003, comprised a set of process indicators generated from village and higher levels, and reflected mainly the extent and quality of coverage of the best practices and related processes. The operational strategy, based on recommendations of previous evaluations of INHP, had envisaged the need for measuring outcomes at periodic intervals and at disaggregated levels, and the ELS experience also indicated that it was not sufficient to just track processes. After considering several options, it was decided to constitute a panel of one district from each state, where household surveys would be conducted annually to track levels of achievement of critical outcomes and related processes, such as contacts between service provider or volunteers (Change Agents) and families – information that was otherwise not available from existing sources. These were designed as periodic rapid assessments, called RAPs for short, using the first 25 percent of replication sites as the universe in each of the panel districts. Eventually, three more or less annual rounds of RAPs were conducted with the help of professional research organizations during 2003 to 2005, of which the first served virtually as a baseline.

The very low levels of many indicators, including service coverage, key behaviors and what were beginning to be recognized as key processes – contacts, include home visits by service providers – were a revelation to various stakeholders, at the end of the first survey in 2003.

Also, in late 2003, the program first experimented with the direct engagement of key district officials and sub-district functionaries in participatory planning exercises and discovered that this was an effective way of getting the close attention of these functionaries to focus on operational problems, for which they began finding their own solutions. In many places, the best practices came naturally as possible solutions for the operational problems. This was applied more widely in the eight panel districts once the results of the first round of RAPs were available. The results, when shared, provoked the systems into immediate action. In some districts, such action planning was well focused and executed, but not in all. Some of the best results that were ultimately seen in the program came from some of these districts. These planning exercises threw up examples of how systems could make themselves more accountable to focused interventions with the use of simple tools such as supervisors' checklists for use during their field visits, or how AWW could make focused home visits through the use of a modified home visit register/planner. The key roles that district collectors could play once they had evidence for what was crucial was also revealed. Simultaneously, it also became clear how much less focused districts were that did not have the benefit of generating their own outcome level data.

By the end of 2004, results from the second round of RAPs were available and showed variable but small changes in behavior and service delivery related

indicators in most of the districts. It became clear that improvements had happened, but were clearly insufficient to bring about the envisaged impact. This was humbling. Another finding was that CAs were not reaching a large proportion of households as they had been expected to do, while the AWWs and the ANMs were now widening their reach quickly, and were reaching the same families assigned to the CAs and many more. This was different from what had been predicted when CAs were first recruited with the understanding that they would make contacts with families to provide relief to the apparently stressed AWWs and ANMs.

The program strategy clearly needed refinements and the mid-term review was an opportunity to introduce strategic refinements.

Key Refinements and Shifts

Taking into consideration the mid-term review findings and all the lessons up to then, a revised strategy was put into place. Central to this strategy was directly engaging systems in using evidence to identify and solve problems at the district level and strengthening accountability mechanisms to ensure operational focus on critical maternal and child health and nutrition interventions.

Strengthening Supervisory Systems: The ICDS sector supervisor was identified as the lynchpin of this strategy – if she could be helped to utilize her sector meetings and her field visits well, interventions could reach full scale almost immediately. She and the AWW needed simple tools to help them focus correctly on interventions and approaches that were most likely to be effective. Early versions of such tools were already in use in some of the panel districts, and experience from other districts too had thrown up good ideas. These were refined into a set of generic tools and sent out to all districts for local adaptation and use. Interactions with the ICDS functionaries in a few districts revealed that the program was willing to consider restructuring sector meetings to enable concrete program content to be discussed between the supervisor and the AWWs; the Health department was also willing to make arrangements for the ANMs to regularly attend such meetings. Simple tools and checklists were drawn up for supervisors, again using early versions already in use elsewhere in the program. Most of the capacity building of AWWs and ANMs would now happen on an ongoing basis, during sector meetings, where the raising of operational issues provided opportunities to learn and improve.

Synergizing Efforts at the Sector Level: A mechanism was needed to provide hand-holding to ICDS Supervisors in conducting effective sector meetings and field visits until they learnt to do it on their own. With each CARE district team member taking care of three to four blocks, there were not enough hands to cover all sector meetings, and the Child Development Program Officer (CDPO) were too busy with their administrative responsibilities to focus on this. NGO support until then was focused on taking care of demonstration sites was redirected to provide one staff member per block who could accompany sector supervisors to meetings as well as field visits as they did in demonstration sites. The NGO staff supported the sector supervisor as well as the CDPO and coordinated with the RACHNA district team to ensure the content and process integrity of the program. It was decided that to enable the RACHNA district teams to concentrate on these post-midterm refinements, the best practices, especially the scale up of CAs would be

promoted as a possible solution to the problems faced by the system rather than as a practice for automatic scale up. However, the existing CAs continued to be supported by systems staff, primarily AWWs and their Supervisors.

From Structured Trainings to Hands-on Training and Problem Solving: The refined approaches to reaching the program universe, the need for linking training with program implementation, and the constraints of time for training large numbers of persons, informed the midterm refinements to capacity building. The focus was more on on-the-job capacity building through sector meetings, and supervisory interactions rather on structured training. The emphasis was on building the capacities of supervisory staff of ICDS and Health and NGO members so as to support the AWWs and ANMs. The existing capacity building modules and training materials were modified to suit this approach. Many states drew up plans for delivering critical contents through short modules to be introduced during monthly sector level meetings. This strategy was established on the ground in most districts over the first six to nine months of 2005, with the active cooperation of the district administration.

Specific Focus on Select Interventions Most Likely to Improve Outcomes: Consistently, one clear lesson was to using available evidence to convince key leaders of the need to get the ICDS and Health programs to focus sharply on a few critical interventions like antenatal care, community based newborn care, primary immunization, supplementary feeding, infant and young child feeding and micro-nutrient supplementation, to make a measurable difference on outcomes. In the case of *Chayan*, heightened emphasis was given to ensure treatment outcomes for STI/RTI cases, beyond identification and referrals. The process of identifying qualified service providers from public and private sources and linking them with communities were accelerated. Referral slips were developed to improve treatment seeking and follow up for treatment compliance. By and large, these changes were acceptable to the system staff, who found the approach more meaningful. As indicated, these were widely used with local adaptations of form and content, and many variants can be found in the field today.

Using Monitoring Data for Program Refinements and Actions: Recognizing the need to change the M&E plan to correspond to the change in strategies, refinements were made. These included reducing HMIS data coming up to Delhi; the rest was decentralized given the strong results-orientation and largely integrated into government systems. Many districts used locally generated process/output data to inform program planning in each district, wherever possible. Short rapid surveys, called "mini-RAPs", were used in 53 districts, in addition to RAPs in the panel of eight districts as previously mentioned. The RAPs and Mini-RAPs were envisaged as helping in shifting the focus of the systems to monitor critical processes and outcomes which are meaningful to help achieve program impact.

Rethinking Geographical Focus: The post-midterm approach also called for identification of geographical areas needing differential focus so as to maximize results from "better" districts/blocks. To ensure focus on areas that can make a major difference with minimal inputs given the time limits, the roles of CARE

district team members were realigned to match the refinements in implementation approach. All team members in the rural team were responsible for specific geographical locations for supporting implementation, in addition to the functional roles and responsibilities that came along with their specific positions.

Refinements to the Roles of CARE District Teams and NGOs: While the work division between members of the district teams of INHP was functional to begin with, it became obvious that a geographical redistribution of the project area among these members could provide greater efficiencies in reaching scale. Accordingly, each district team member was assigned 3-4 blocks. Similarly, NGOs partners, who managed the demonstration sites, were requested to place a staff in each block who could provide hands-on support to sector and block level processes. In this manner, the unit of implementation became one INHP district team member along with the NGO staff in the 3-4 blocks under him or her. Each Regional Manager in the state Program Management team remained responsible for a certain number of districts in each state, and oversaw the work of these district teams.

These refinements, initiated in early 2005, took more than six months to fully establish, and the project achieved full momentum in the latter half of 2005. The project was eventually evaluated in April 2006, to provide time for winding down and transitioning into the next phase, INHP-III by the end of 2006.

The paper, *A Cost Analysis of the RACHNA Program,* in this series, provides a detailed account of what it cost to implement INHP-II.

RACHNA is one of the largest NGO public health programs around the world. The lessons from this program become very important to the larger national programs as RACHNA worked very closely with the ICDS and RCH programs at a large scale in multiple contexts.

The journey of RACHNA has brought out many important lessons, which are discussed in the different papers in this series.

CARE-India, August 2008

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This publication was made possible through support provided by the United States Agency for International Development. The opinions expressed in this publication are those of the author(s) and do not necessarily reflect the views of the United States Agency for International Development or the United States government.

About RACHNA

Two major projects of the Reproductive and Child Health, Nutrition and HIV/AIDS (RACHNA) program of CARE-India completed five years of work supported by funds from USAID in late 2006. The second phase of Integrated Nutrition and Health Project (INHP-II) was aimed at helping reduce child malnutrition and mortality. The rural component of the *Chayan* project primarily addressed the unmet need for spacing methods, while its urban component attempted to reduce HIV transmission among at-risk groups. Together, the projects covered 78 districts and 22 cities, spread over 10 states, and worked closely with key national programs and a spectrum of different partners. This series of working papers documents the results and lessons from these five years.

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